

Development of an Acceptance and Commitment Therapy Workshop for Diabetes

Laura Melton

Presentation

This case describes the development of an Acceptance and Commitment Therapy (ACT) workshop for people with diabetes, designed to help meet the acute need for quality psychological care for patients. There were multiple considerations in developing the quality improvement program:

1. The group nature of the program. Group environments enhance social modeling and provide support not possible in individual therapy.
2. Efficiency and resource management. This workshop does not duplicate resources already offered.
3. Time commitment of participants. The group consisted of four 90-minute sessions, which we believed would be an adequate amount of time to teach the desired ACT intervention based on previous work (1).
4. Reduction of stigmatization and increase in participation. We wanted to avoid the words “therapy,” “intervention,” and “group.” The intervention was titled “Living a Vital Life with Diabetes” and was referred to as “A 4-Part Workshop Series.”

The program curriculum was adapted from a multitude of ACT sources (2–5). The ACT model has six core components that work together flexibly such that each core component is connected to the others. The six core components are 1) contact

with the present moment, 2) values, 3) committed action, 4) self as context, 5) cognitive defusion, and 6) acceptance.

The “acceptance” and “committed action” portions of ACT are often presented as follows: acceptance of the thoughts, feelings, memories, and body sensations (which is your private experience) and commitment to doing what really matters to you in the situation (living by your values) (3). The six core components of ACT help individuals understand what they are feeling but do not necessarily make them feel better.

Admittedly, ACT can be confusing for both therapists and patients as they are learning it (4). Given our limited interaction time with patients, we focused on providing a brief introduction to each of the six core components by dividing the concepts up over the course of the four-part workshop.

The first session focused on the core components of “values” and “being present.” In each session, ACT exercises and visuals were used to teach the information, followed by a prompted group discussion about how the information relates to participants’ diabetes. Session one exercises include a “values” exercise, a “being present” metaphor to help introduce mindfulness, and an exercise focused on mindfulness (“being present”).

The second session focused on the ACT component of “cognitive defusion” and introduced “acceptance.” The session began with a mindfulness

University of Colorado, Denver

Corresponding author: Laura Melton,
laura.melton@ucdenver.edu

DOI: 10.2337/cd15-0040

©2016 by the American Diabetes Association. Readers may use this article as long as the work is properly cited, the use is educational and not for profit, and the work is not altered. See <http://creativecommons.org/licenses/by-nc-nd/3.0> for details.

exercise. A “cognitive defusion” exercise and two exercises focused on the core value of “control as the problem” were included in the session.

The third session focused on the components of “self as context” and “acceptance.” Again, a mindfulness exercise opened the session before the group completed exercises on these core components.

In the fourth and final session, previous topics were reviewed, and there was a focus on the ACT component of “committed action.” Again, the group started with a mindfulness exercise. A significant portion of the session was spent reviewing previously presented content, including the specific metaphors and exercises, as well as a review of how the information relates to participants’ diabetes. Finally, participants identified personal “values” and participated in a “committed action” exercise.

The goal of this pilot program was to design and implement an ACT workshop for diabetes. The appropriate outcome measure for this stage of the program’s development was a qualitative assessment of learning that occurred during our review in the fourth session. Participants with higher attendance rates had a higher rate of participation in the review and seemed to have a better understanding of the ACT information presented. Overall, five participants attended one session, three participants attended two sessions, two participants attended three sessions, and no participants attended all four sessions.

Questions

- How can we increase patients’ access to psychosocial support regarding their diabetes?
- Is ACT a viable option for patients with diabetes?
- Can ACT be offered in a workshop style with stand-alone sessions to facilitate increased attendance?

Commentary

Individuals with diabetes are at increased risk for developing depres-

sion (6). When people with diabetes are distressed or have a low level of acceptance of their disease, their adherence to diabetes management is lower, which has a negative impact on glycemic control (7,8).

The most commonly used psychological approaches to help patients manage diabetes are based on cognitive behavioral therapy (CBT) (9), with interventions aimed at lowering distress and improving glycemic control. Although CBT interventions in diabetes patients are effective in lowering distress symptoms (9,10), research has not found CBT to reliably improve blood glucose or have a positive effect on weight control (9), and findings relating to the impact of CBT on A1C have been inconsistent (9,10). Additionally, the traditional CBT model of eliminating or changing difficult thoughts or feelings may not be a realistic strategy because recurring diabetes self-management behaviors themselves may evoke distress.

ACT has been shown to be helpful in patients with diabetes (1,11). Individuals who received psycho-education and ACT interventions had better outcomes (i.e., A1C in the target range, increased diabetes self-care behaviors, and increased use of coping strategies) compared to individuals who received only diabetes psycho-education (1). Whereas CBT aims to help people eliminate or change the difficult or negative thoughts and feelings they have been attempting to avoid, ACT endeavors to help people accept those thoughts and feelings. Instead of focusing on the actual thoughts or feelings, ACT focuses on avoidance of the thoughts or feelings (4). By using a personalized approach, ACT fosters patient autonomy by supporting patients’ individual efforts to assess their values and, if desired (not required), change their behavior.

Clinical Pearls

- Patients with diabetes need assistance beyond medication and education.

- To meet the growing demand for psychosocial services, clinics will need to consider offering therapy groups to help patients cope with the lifestyle changes often associated with diabetes management.
- The ACT model for diabetes intervention has great potential for this purpose.
- ACT for diabetes can be offered in a group setting, with each session designed with stand-alone content to facilitate patient attendance; participants can join the group on dates they are available and will not be excluded from participating if they are unable to attend all of the sessions.
- ACT-based interventions may be beneficial to increase patient self-efficacy and, subsequently, help patients manage their diabetes.

Duality of Interest

No potential conflicts of interest relevant to this article were reported.

References

1. Gregg J, Callaghan GM, Hayes SC, Glenn-Lawson JL. Improving diabetes self-management through acceptance, mindfulness, and values: a randomized controlled trial. *J Consult Clin Psychol* 2007;75:336–343
2. Gregg J, Callaghan GM, Hayes SC. *Acceptance and Commitment Therapy for the Self-Management of Diabetes*. Oakland, CA, New Harbinger Publications, 2007
3. Walser RD, Westrup D. *Acceptance and Commitment Therapy for the Treatment of Post-Traumatic Stress Disorder and Trauma-Related Problems*. Oakland, CA, New Harbinger Publications, 2007
4. Luoma JB, Hayes SC, Walser RD. *Learning ACT: An Acceptance and Commitment Therapy Skills-Training Manual for Therapists*. Oakland, CA, New Harbinger Publications, 2007
5. Bach PA, Moran DJ. *ACT in Practice: Case Conceptualization in Acceptance and Commitment Therapy*. Oakland, CA, New Harbinger Publications, 2008
6. Semenkovich K, Brown ME, Svrakic DM, Lustman PJ. Depression in type 2 diabetes mellitus: prevalence, impact, and treatment. *Drugs* 2015;75:577–587
7. Park M, Katon WJ, Wolf FM. Depression and risk of mortality in individuals with diabetes: a meta-analysis and systematic review. *Gen Hosp Psychiatry* 2013;35:217–225

8. Schmitt A, Reimer A, Kulzer B, Haak T, Gahr A, Hermanns N. Assessment of diabetes acceptance can help identify patients with ineffective diabetes self-care and poor diabetes control. *Diabet Med* 2014;31:1446–1451
9. Ismail K, Winkley K, Rabe-Hesketh S. Systematic review and meta-analysis of randomized controlled trials of psychological interventions to improve glycaemic control in patients with type 2 diabetes. *Lancet* 2004;363:1589–1597
10. Snoek FJ, van der Ven NCW, Twisk JWR, et al. Cognitive behavioural therapy [CBT] compared with blood glucose awareness training [BGAT] in poorly controlled type 1 diabetic patients: long-term effects on HbA1c moderated by depression: a randomized controlled trial. *Diabet Med* 2008;25:1337–1342
11. Pull CB. Current empirical status of acceptance and commitment therapy. *Curr Opin Psychiatry* 2009;22:55–60